HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume V, Number 9 June 2000

HEALTH watch

Medicare to Increase Payment Rates to Protect Nursing Home Residents with High-Cost Medical Needs

HCFA Administrator Nancy-Ann DeParle announced in early April that Medicare is increasing the payment rates to skilled nursing facilities for those residents who have the most costly medical needs.

The proposed changes, which take effect on October 1, 2000, will increase overall Medicare payments for skilled nursing care by an estimated 5.8 percent above the published rates for Fiscal Year 2000.

The proposal also creates new, higher payment categories for residents with multiple, serious health problems that require intensive care and treatment. The proposed changes result from HCFA research, and are intended to refine the payment system to ensure that Medicare paid appropriately based on individual needs. Additional research will be completed before the changes are implemented.

Medicare payment rates for skilled care following hospitalization are based on a prospective payment system, as required by the Balanced Budget Act of 1997 (BBA). Hospitals have been paid under a prospective payment system since 1983.

The nursing home payment system was implemented in 1998 as a way to provide quality, efficient care. Under the system, payment rates to skilled nursing

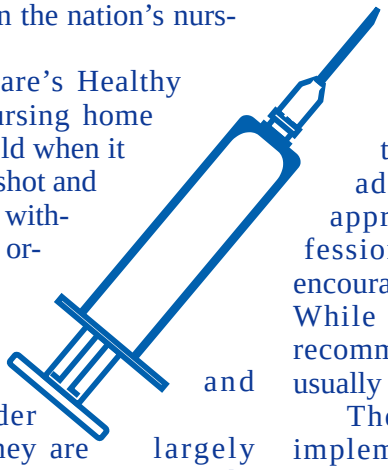
See **PAYMENT,** page 7

Cooperative Venture of HCFA and the Centers for Disease Control and Prevention (CDC)

Medicare Initiative Aims at Getting Seniors to Get Flu Shots

Building on the earlier success of its campaign to get more older Americans vaccinated against the flu, Medicare is sponsoring a new pilot program that will make annual flu and pneumonia shots almost automatic in the nation's nursing homes.

Under Medicare's Healthy Aging Project, nursing home residents will be told when it is time to get a flu shot and will be able to get it without a new doctor's order each year.



Flu and pneumonia are leading causes of sickness and death among older Americans, yet they are largely preventable through immunization. Public and provider education efforts have raised immunization rates in recent years, but research by the Health Care Financing Administration, the federal Medicare agency, and others suggests that new measures are needed to reach the rest of the senior population.

Placing permanent entries in nursing home residents' medical charts will ensure that they get a personal reminder when it is time for a flu shot which can be administered on the spot by appropriate health care professionals. The project will also encourage pneumonia immunization. While annual flu shots are recommended, one pneumonia shot usually is good for a lifetime.

The pilot project is being implemented in the District of Columbia, Florida, Hawaii, Idaho, Kentucky, Massachusetts, Minnesota, Montana, New Mexico and Washington

See **INITIATIVE,** page 5

Nearly two-thirds of Americans age 65 and older are getting their flu shots, but we expect to boost that dramatically under this new initiative. We hope flu shots will become a part of the nursing home routine.

—DONNA E. SHALALA, HHS Secretary

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

MISSION —We assure health care security for beneficiaries.
VISION — In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.
GOALS — Protect and improve beneficiary health and satisfaction • Promote the fiscal integrity of HCFA programs • Purchase the best value health care for beneficiaries • Promote beneficiary and public understanding of HCFA and its programs • Foster excellence in the design and administration of HCFA's programs • Provide leadership in the broader public interest to improve health.
OBJECTIVES — ***Customer Service*** • Improve beneficiary satisfaction with programs, services and care • Enhance beneficiary program protections • Increase the usefulness of communications with constituents, partners, and stakeholders • Ensure that programs and services respond to the health care needs of beneficiaries.
Quality of Care • Improve health outcomes • Improve access to services for underserved and vulnerable beneficiary populations • Protect beneficiaries from substandard care.
Program Administration • Build a high quality, customer-focused team • Enhance program safeguards • Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds • Increase public knowledge of the financing and delivery of health care • Improve HCFA's management of information systems/technology.

NANCY-ANN DEPARLE, *Administrator*

PETER GRIFFIN, *Acting Director,*
Office of Communications &
Operations Support

CYNTHIA WARK, *Director,*
Communications Strategies &
Standards Group

HEALTH WATCH TEAM

JON BOOTH.....410/786-6577
JUSTIN DOWLING.....617/565-1261
WILLIAM KIDD.....Relay: 800/735-2258
410/786-8609
DONALD MCLEOD.....202/690-7183
MILDRED REED.....202/690-8617
DAVID WRIGHT.....214/767-6346

You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/news/newsltrs/newsltr.htm***. Also, should you wish to make an address change or comment on an article, send your E-mail to ***healthwatch@hcfa.gov***.

Message from the Administrator

NANCY-ANN DEPARLE

THE HEALTH CARE FINANCING ADMINISTRATION is delivering on its promise to make Medicare coverage decisions more open, understandable and predictable and to reach decisions promptly.

Medicare has made more than a dozen national coverage decisions under a new process launched just over a year ago. The first was a national coverage decision for infusion pumps that provide better glucose control for beneficiaries with diabetes.

A decision announced last September expanded treatment options for Medicare beneficiaries with diabetes by covering insulin infusion pumps for eligible beneficiaries with Type I diabetes. This decision resulted from a review of previous policy initiated within HCFA. And Medicare reached a decision within the 90-day deadline that the new process sets.

Another recent decision expands Medicare coverage of protein A columns to include treatment for beneficiaries with severe rheumatoid arthritis who do not respond to conventional drug therapies. This decision will not affect the great number of Medicare beneficiaries with rheumatoid arthritis who can and do benefit from disease-modifying drugs, but for the few who can't be helped by conventional treatment this is a very important new benefit.

HCFA took another major step toward improving the coverage decision process when it published in the *Federal Register* in May a notice of intent that is the first step in developing national criteria for what is reasonable and necessary. By law, Medicare may not pay for services or items that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

For more than three decades HCFA has made coverage decisions, determining in each case whether something is reasonable and necessary. But experience has shown that a standardized national definition of these terms is needed for more consistent and timely decision making and to expand access to appropriate new technologies for Medicare beneficiaries.

The notice of intent suggests two criteria that might be applied in making national coverage decisions. First, an item or service would have to be shown to have medical benefit. The second condition might be that the item or service would demonstrate added value for people in Medicare.

In most cases cost would not be considered in making a coverage a decision. In general, cost would not be considered if a new item or service would be medically beneficial and there is no Medicare-covered alternative available.

We're committed to achieving a national definition of "reasonable and necessary" that will provide consistency and greater understanding to the process and bring the best, most advanced services and items to Medicare's more than 39 million beneficiaries.

At the same time, HCFA has already broadened the scope of "medically necessary service." Over the past few years, we have added some of the most necessary services of all — those that treat small problems before they become big ones.

Illinois and Pennsylvania's State Children's Health Insurance Programs Expand

Department of Health and Human Services (HHS) Secretary Donna E. Shalala recently approved two proposals from Illinois and Pennsylvania to further expand their State Children's Health Insurance Program (SCHIP) plans to provide health insurance to thousands of children who otherwise would not have coverage.

The SCHIP is historic, bipartisan legislation signed in 1997 by President Clinton that appropriates $24 billion over five years to help states expand health insurance to children whose families earn too much for traditional Medicaid, yet not enough to afford private health insurance. Illinois and Pennsylvania, like all states with approved SCHIP plans, will receive federal matching funds only for actual expenditures to insure children.

SCHIP plans have now been approved for all the states and territories.

State and SCHIP Funds	No. of Children	Eligibility (Based on $17,050 annual income for family of four)
Illinois $121M	New group of 20,000 children in addition to 40,000 children who were enrolled in FY 1999	Illinois' initial SCHIP plan, a Medicaid expansion, was approved by Secretary Shalala on April 1, 1998. The amendment approved on March 30, 2000 consists of a separate SCHIP program for children below age 19 in families with income levels between 133 percent and 185 percent of the federal poverty level (FPL). For families with incomes above 133 percent of poverty, there will be some cost-sharing requirements. But, under the SCHIP law, family cost-sharing cannot exceed 5 percent of the family's income. There are also no cost-sharing requirements for American Indian/Alaskan Native children. There will be no premiums charged to families whose income is below 150 percent of the FPL and 185 percent FPL with one child, a monthly premium of $15 will be charged. For families in this income level with two children, $25 per month will be charged; and $30 per month will be charged for families with three or more children.
Pennsylvania $17M	New group of 15,000 children in addition to 82,000 children who were enrolled in FY 1999	Pennsylvania's initial SCHIP plan, an expansion of the state's pre-existing PA CHIP program, was approved by Secretary Shalala on May 29, 1998, and its first amendment was approved on October 29, 1998. On March 6, 2000, the second and third amendments to Pennsylvania's plan were approved. The second amendment will expand income eligibility by deducting child care and work expenses from total income. The third amendment will add outpatient mental health services, inpatient and outpatient substance abuse services, rehabilitation services, and disposable medical supplies. Families with incomes below 200 percent of the FPL are eligible for PA CHIP. There is no cost-sharing for families in PA CHIP.

Selected Health Issues on the *Web*

http://www.imrp.net

All current Local Medical Review Policy (LMRP) documents are on the Internet. Local Medical Review Policy is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. Local policies outline how contractors will review claims to ensure that they meet Medicare coverage requirements. HCFA requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice. Contractor medical directors develop these policies.

http://newfederalism.urban.org/pdf/b15.pdf

Gaps in Prevention and Treatment: Dental Care for Low-Income Children
BY GENEVIEVE M. KENNEY, GRACE KO, AND BARBARA A. ORMOND

Low-income children are almost twice as likely as high-income children to have unmet dental needs, claims this report on the Urban Institute's Web site: "Under Medicaid, the solution may lie less in a change in policy than in better adherence to existing requirements."

http://www.gao.gov/new.items/he00108t.pdf

Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure
T–HEHS–00–108, May 4, 2000

Testimony before the Committee on Finance, U.S. Senate, relates to focusing on the issues HCFA faces in administering Medicare today and the extent to which proposed reforms or alternative models might address these issues.

http://www.gao.gov/new.items/he00106t.pdf

Privacy Standards: Issues in HHS' Proposed Rule on Confidentiality of Personal Health Information
T–HEHS–00–106, April 25, 2000

Testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate, indicates that few areas of our lives are thought to be more private than our health and medical care. However, the proliferation of electronic records and managed care arrangements becomes worrisome as to how health care information is protected from inappropriate disclosure. Disclosing personally identifiable medical information without authorization may reveal information that an individual wishes to remain confidential. There is concern that access may subject an individual to discrimination in employment, insurance, or other matters.

Two HCFA Employees Honored for Leading Charity Drive

Employees of the Health Care Financing Administration contributed a record-breaking total in the Combined Federal Campaign for the year 2000.

Vaughn Ouellette and Ada Talbert have been recognized for their efforts in encouraging HCFA employees to make donations to various charities through the federal campaign.

Employees in HCFA's Baltimore headquarters contributed a record-breaking $340,000, about $43,000 higher than the goal, and $56,000 above the previous year's record. Nearly half of the employees in Baltimore participated in the charity drive and the number of employees pledging $1,000 or more rose from 61 to 99.

VAUGHN OUELETTE

Ouellette, who works in HCFA's Office of Internal Customer Support, was the overall coordinator for the central Maryland area including HCFA.

ADA TALBERT

Talbert, who is in the Office of Legislation, led the drive in the Washington office, which was the only HCFA office to achieve 100 percent employee participation. The office reached 100 percent of its goal with about $24,000 in contributions.

Across the nation, HCFA staff set another agency record by contributing $551,000 to the campaign, an increase of nearly $90,000 over 1998. In addition, 138 employees nationwide contributed at least 1 percent of their salary or $1,000 or more, and about 70 percent of the contributions were pledged through payroll deductions.

INITIATIVE from page 1

in time for the 2000 fall flu season. Alaska, Mississippi and Oregon are also doing separate projects using peer review organizations, HCFA's contractors for quality assurance, to have standing orders for flu and pneumonia shots included in the records of nursing home residents. With these orders in place, nursing homes will be able to assure that virtually every resident gets an annual flu shot.

Between 20,000 and 40,000 deaths are attributed to flu and pneumonia in the United States each year. More than 90 percent of the deaths occur in people age 65 and older. Among elderly nursing home residents, influenza vaccination can be 50 to 60 percent effective in preventing hospitalization or pneumonia, and 80 percent effective in preventing death. Pneumococcal vaccination is 60 to 70 percent effective in preventing invasive (bacterial) pneumococcal infection.

Medicare has covered flu shots since 1993 and pneumonia vaccinations since 1981. HCFA has conducted an aggressive campaign to get Medicare beneficiaries inoculated against these major killers of older Americans, and annual promotions such as public service announcements, posters and general mailings have succeeded in getting most seniors immunized. By 1997, 63 percent of older Americans got the flu shot, exceeding the goal of 60 percent that had been set for the year 2000, and 42 percent got pneumonia shots.

A report done for HCFA by RAND, a private research and consulting firm, concluded that getting the remaining 37 percent inoculated will require other approaches such as standing orders.

The HCFA research found that standing orders are more effective than traditional patient reminders in getting people immunized. HCFA and CDC also are recommending additional steps to increase immunization, including provider reminders, such as stickers placed on medical charts or computer messages, and personalized cards or letters to patients from their doctors.

In the Limelight

Montgomery County, Md., Resident Honored for Helping Medicare Beneficiaries Get Medical Services

Pamela Schmidtke Collins, a resident of Silver Spring, Md., was recognized as the Health Care Financing Administration employee of the month for February. A four-year HCFA employee, Collins works as a contracting officer in the Office of Internal Customer Support at HCFA, the agency that administers Medicare and Medicaid. Collins is one of about 2,800 employees in the agency's Baltimore headquarters.

PAMELA COLLINS

HCFA honored Collins for a number of contracts primarily related to the agency's successful effort to prepare for Year 2000 and provide guidance to a staff of contract specialists to help ensure HCFA's data systems were Y2K ready.

The contracting process enables HCFA to award contracts to bidders providing the best value to the government. Through Collins' efforts, HCFA further improved this system by reducing the time between bid development and contract award, thus allowing the agency to get needed supplies, services and equipment more quickly.

"Pam Collins' expertise helps HCFA get Medicare beneficiaries quality care and saves tax dollars," HCFA Administrator Nancy-Ann DeParle said. "I also congratulate her for helping train and lead other contract specialists in HCFA. Her efforts helped ensure our Y2K success and value for beneficiaries and Medicare."

"HCFA is very fortunate to have someone with Pam's exceptional contracting skills working for us," said Mike Odachowski, Director of the Office of Internal Customer Support. "These contracting skills became very evident when she helped the agency meet the Y2K challenge by awarding numerous urgent contract actions. She is truly an asset and the Office of Internal Customer Support is very proud to have Pam as part of our team."

"I feel proud and privileged to work in an organization whose mission is to assure health care security for over 75 million beneficiaries," Collins said. "Health care impacts each and every one of us, and it is truly gratifying to be part of such an important endeavor."

Calendar of Events

June 26
Administrator Nancy-Ann DeParle speaks at the HCFA and Department of Justice Fraud Conference in Crystal City, Va., on *HCFA's Interests and Issues.*

Contractors Selected to Process Medicare Part B Claims in Five States

Five companies have been selected as Medicare Part B claims processors for Connecticut, Minnesota, Mississippi, Virginia and California..

The first four companies will take over the work of United Health Group, based in Minneapolis. The fifth company, National Heritage Insurance Company of Plano, Texas, will take over the work of Transamerica Occidental Life Insurance Company. Both United Health Group and Transamerica Occidental Life decided to discontinue participation in the Medicare fee-for-service program. Part B contractors, known as carriers, process claims for physicians and other medical services under contracts with HCFA.

Health care for seniors and disabled people in Medicare will not be affected by these changes because these companies process and pay claims for providers that treat Medicare beneficiaries. Those claims will continue to be paid promptly.

All of the replacement contractors are now involved in Medicare claims processing. The contractors are listed at the bottom of the page.

The numbers in the table are estimates. These transitions will be completed by September 30, 2000.

By law, private insurance companies process Part A claims for hospitals and other providers and pay Part B claims for physicians and other medical services under contracts with HCFA.

United Health Group also served as the Part A Medicare claims processor for hospitals and other medical facilities in Connecticut, Michigan and New York. Following United Health Group's decision to leave the program, HCFA selected Empire Blue Cross and Blue Shield to process Part A claims in Michigan. These selections were made in consultation with the Blue Cross and Blue Shield Association, the prime contractor.

HCFA is selecting a replacement for United Health Group as the durable medical equipment claims processor for the New England states: Delaware, New Jersey, New York and Pennsylvania.

Company	State	Beneficiaries	Providers	Physicians	Comments
Blue Cross and Blue Shield of Florida Inc. Jacksonville, Fla.	Connecticut	710,000	17,000	12,800	Company does business as First Coast Service Options Inc. It is the Part B contractor for Florida.
Wisconsin Physicians Service Madison, Wisc.	Minnesota	700,000	22,000	17,000	Wisconsin Physicians Service is currently the Part B contractor for Illinois, Michigan and Wisconsin.
Blue Cross and Blue Shield of Alabama Birmingham, Ala.	Mississippi	470,000	10,000	8,200	Company does business as Cahaba Government Benefits Administrators. It is currently the Part A and Part B contractor for Alabama and the Part B contractor for Georgia.
TrailBlazer Health Enterprises Inc. Richardson, Tex.	Virginia	820,000	22,000	15,000	The company is a subsidiary of South Carolina Blue Cross and Blue Shield. It is currently the Part B contractor for Delaware, Maryland, Texas, northern Virginia and Washington, D.C.
National Heritage Insurance Co. Plano, Tex.	California	1,700,000	33,000	—	National Heritage will now be the Part B contractor for the entire state. It already serves as the Part B claims processor for northern California, as well as Maine, Massachusetts, New Hampshire and Vermont. Providers are in Imperial, Los Angeles, Orange, San Diego, Santa Barbara, San Luis Obispo and Ventura counties.

PAYMENT from page 1

facilities cover the costs of furnishing most covered services. These include allowable post-hospital nursing home services provided by Medicare Part A, which covers inpatient care.

HCFA moved quickly to implement the rate updates, which are based on increases in the cost of covered care, changes in geographic variation in wages and provisions of the BBA and the Balanced Budget Refinement Act of 1999, which was enacted in November.

Under the prospective payment system, each facility receives a base payment amount adjusted for local wages and the clinical characteristics of individual patients. Covered costs include routine services such as room, board, nursing services, and minor medical supplies; ancillary costs such as therapies, drugs and lab services; and capital costs including land, building and equipment.

This payment system is designed to ensure better patient care by relating payments to the condition of the patient, recognizing that some need more services or more expensive care than others, rather than a set amount per patient. Under the previous system, the skilled nursing facility benefit was one of the fastest growing components of Medicare spending.

Under the proposed refinements:

• Medicare would pay more than $700 per day for residents with the most intensive medical needs — more than five times the rate for residents with the least intensive needs.

• Payment rates will better account for the costs of providing drugs and other non-therapy ancillary services.

• Payments would be adjusted to reflect wage differences and a facility's historical costs.

The prospective payment system has been phased in to ease the transition for nursing homes. During the first three years of implementation, the rate for a nursing home is determined by a blend of a facility specific rate and a federal rate. In the third year, which begins as early as July 1, 2000, for some nursing homes, the blend is 25 percent of the facility rate and 75 percent of the national rate. Nursing homes also have the option of being paid entirely at the federal rate now, and all homes will be paid based on the federal rates starting in the fourth year.

The proposed rule for the refinements and payment increases was published in the April 10 *Federal Register* with a 60-day period for public comment. A final rule will be published this summer.

Implementing this improved payment system is one of a series of steps underway to helping residents receive the quality care that they deserve.

In 1998, the Clinton Administration began an aggressive initiative to improve enforcement of federal and state standards and to promote quality care for residents. HCFA now requires states to crack down on homes that repeatedly violate health and safety standards and has strengthened the inspection process to increase its focus on preventing bedsores, malnutrition and abuse. In addition, HCFA has created *Nursing Home Compare*, a searchable database available at ***www.medicare.gov***, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents.

New Regulations/Notices

Medicare Program; Process for Requesting Recognition of New Technologies and Certain Drugs, Biologicals, and Medical Devices for Special Payment Under the Hospital Outpatient Prospective Payment System [HCFA–1128–N] — Published 4-7. HCFA expects to implement a prospective payment system for hospital outpatient services for the Medicare program on July 1, 2000. This system will recognize new technology as discrete payment groups within the ambulatory payment classification (APC) system. This payment system will also provide for additional payments to hospitals at amounts higher than the amounts that would otherwise be paid for certain specified items, such as: orphan drugs; drugs, biologic agents, and brachytherapy devices used for the treatment of cancer; radiopharmaceutical drugs and biologic products; and certain new and/or innovative medical devices. HCFA has identified items or services for inclusion in the new technology APC groups, as well as items potentially eligible for special additional payments. This notice addresses the process that interested parties must use to submit additional items for consideration.

Medicare Program; Notice of the Solicitation for Proposals to Expand the Medicare Lifestyle Modification Program Demonstration; Cancellation Notice [HCFA– 3028–N2] — Published 4/7. In the January 5, 2000 issue of the *Federal Register* (65 FR 495), HCFA published a notice soliciting proposals to expand the Medicare Lifestyle Modification Program Demonstration to one additional national multi-site cardiovascular lifestyle modification program. The original solicitation contained an inaccurate description of the intended population to be served by the proposed demonstration. HCFA is withdrawing the request for solicitations of interest in order to correct this mistake, which may affect the types of organizations interested in participating and the composition of their applications, and expect to publish a new request at a later time with the correct description. The effective date is April 7, 2000.

CLIA Program; Cytology Testing [HCFA –2233–N] — Published 3/17. This document announces the withdrawal of a proposed rule on cytology proficiency testing that was published in the *Federal Register* November 30, 1995 [60 FR 61509]. HCFA published the proposed rule to comply with a court order that HCFA revise the regulations to require that cytology proficiency testing (PT) be conducted, "to the extent practicable, under normal working conditions," which the court interpreted to be at a pace corresponding to the maximum workload rate for individuals examining cytology slides. After the proposed rule was published, the appeals court overturned the lower court's ruling and remanded the regulation to HCFA for completion of rulemaking or to provide HCFA's rationale for the original position it took with respect to cytology proficiency testing. This document withdraws the proposed rule and also contains a supplementary statement of rationale, in accordance with the appeals court ruling. This proposed rule is withdrawn as of April 17, 2000.

Medicare Program; Coverage of, and Payment for, Paramedic Intercept Ambulance Services [HCFA–1813–F] — Published 3/15. This final rule responds to public comments received on a final rule with comment period published on January 25, 1999 that implemented section 4531(c) of the Balanced Budget Act of 1997 concerning Medicare coverage of, and payment for, paramedic intercept ambulance services in rural communities. It also implements section 412 of the Medicare, Medicaid, and State Children's Health Insurance Programs' Balanced Budget Refinement Act of 1999 by adding a new definition of a rural area. These regulations became effective on April 14, 2000.

Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services [HCFA–3250–P] — Published 3/10. This proposed rule would establish national coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B to promote Medicare program integrity and national uniformity, and simplify administrative requirements for clinical diagnostic laboratory services. A Negotiated Rulemaking Committee developed the proposed policies.

Department of Health & Human Services
Health Care Financing Administration
7500 Security Boulevard, Mail Stop C5-16-03
Baltimore, Maryland 21244-1850

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

First Class Rate
Postage & Fees
PAID
HHS Permit No. G-28